MB MurphyBattista LLP

Hernia Mesh Class Action

Client Information Questionnaire

Client Identification

Name: ______________________________
(First) (Middle) (Last)

Other Name/Aliases: ______________________________

Current Address: ______________________________

Home Phone: ______________ Cell Phone: ______________

Email: ______________ Date of Birth: ______________

Health Care #: ______________ Marital Status: ______________

Spouse's Name: ______________________________
(First) (Middle) (Last)

Emergency Contact

Name: ______________________________
(First) (Middle) (Last)

Current Address: ______________________________

Home Phone: ______________ Cell Phone: ______________

Email: ______________ Relationship: ______________

Hernia Mesh Information

Approximate date original mesh was implanted: ______________________________

City and hospital where original mesh was implanted: ______________________________

Name and address of surgeon who implanted the original mesh:

Hernia Mesh Information (continued)

Brand name or type of mesh used, if known: ______________________________

Have you received more than one hernia repair: ☐ Yes ☐ No

If yes, for each repair, please list:

a) The approximate dates of each repair:

b) The city/hospital where the repair occurred:

c) The name and address of the surgeon for each repair:

Has your mesh been removed: ☐ Yes ☐ No

If yes, please provide the name and address of the surgeon and the hospital/facility where the mesh was removed:

Has your mesh implant been replaced: ☐ Yes ☐ No

If yes, please provide the name and address of the surgeon and the hospital/facility where the mesh was replaced:

Hernia Mesh Information (continued)

What injuries or symptoms have you experienced or been diagnosed with AFTER the mesh was implanted?

Please check all selections that apply:

- ☐ Hernia recurrence
- ☐ Corrective Surgery
- ☐ Mesh removal
- ☐ Scarring
- ☐ Injury to surrounding organs
- ☐ Bowel/intestinal perforation
- ☐ Bowel/intestinal blockage
- ☐ Difficult bowel movements
- ☐ Blood in stool
- ☐ Mesh migration/movement
- ☐ Abscess or infection
- ☐ Mesh rip or tear
- ☐ Mesh adhesions
- ☐ Abdominal pain
- ☐ Bulging
- ☐ Emotional distress/anxiety/ depression

Other: ____________________

The approximate date when any of the above symptoms first arose AFTER the mesh was inserted:

____

Name and address of the physician(s) who diagnosed you:

Name, address, and specialty of any other doctors involved in your mesh implantation or related problems:

Additional Questions

Future Treatment Plans: ____________________

Do you have your hospital/surgical records: ☐ Yes ☐ No

Name of current GP/family doctor: ____________________

Name of GP/family doctor at time of mesh insertion: ____________________

Name of GP/family doctor at time of mesh removal: ____________________

Employment Information

Status:

- [ ] Student
- [ ] Retired
- [ ] Other: ______________________
- [ ] Employed
- [ ] On Disability
- [ ] Unemployed
- [ ] Social Assistance

If employed:

Type of occupation: ______________________

Employer: ______________________

Date of hire: ______________________

Did you miss work due to an issue with your mesh? ☐ Yes ☐ No

If yes, approximately how much work have you missed? ______________________

If work missed, what is your income? ______________________
(Please provide hourly, monthly, or annually, whatever is most suitable to your circumstances)

Do you have extended medical coverage? ☐ Yes ☐ No

If yes, who is the provider: ______________________

What is the plan or certificate #: ______________________

Have you received disability benefits as a result of your mesh? ☐ Yes ☐ No

If yes, please provide details of amounts and time period:

____

Additional Comments or Other Significant Health Problems or Illnesses Experienced Due to Hernia Mesh (include dates of onset)